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# The Army's Use of Spirituality in the Prevention of Suicide

by

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USAWC STRATEGY RESEARCH PROJECT

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## Abstract

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**The Army's Use of Spirituality in the Prevention of Suicide**

> The Army is committed to providing the best resources for suicide awareness, intervention, prevention, and follow-up care – all of which are critical in helping Soldiers and family members prevent unnecessary loss of life.
>
> —GEN George W. Casey
> (Former) Chief of Staff, U.S. Army[1]

In calendar year 2012, suicides in the Army hit an all-time high of 325. This represents a combined total of 182 Active Duty Soldier suicides and 143 suicides of Reserve Component Soldiers who were not on active duty.[2] The overall trajectory of suicides continues to climb in spite of the robust efforts of the Army's senior leadership to solve the problem; see Figure 1. These efforts include increasing access to behavioral health, creating and authorizing the assignment of 72 additional chaplains, building Soldier resiliency, and strengthening suicide prevention programs.[3] In its current state, the Army's Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention (HP/RR/SP), does not appear to be achieving its goal. In order to reduce suicides, the Army must modify its approach to suicide prevention.

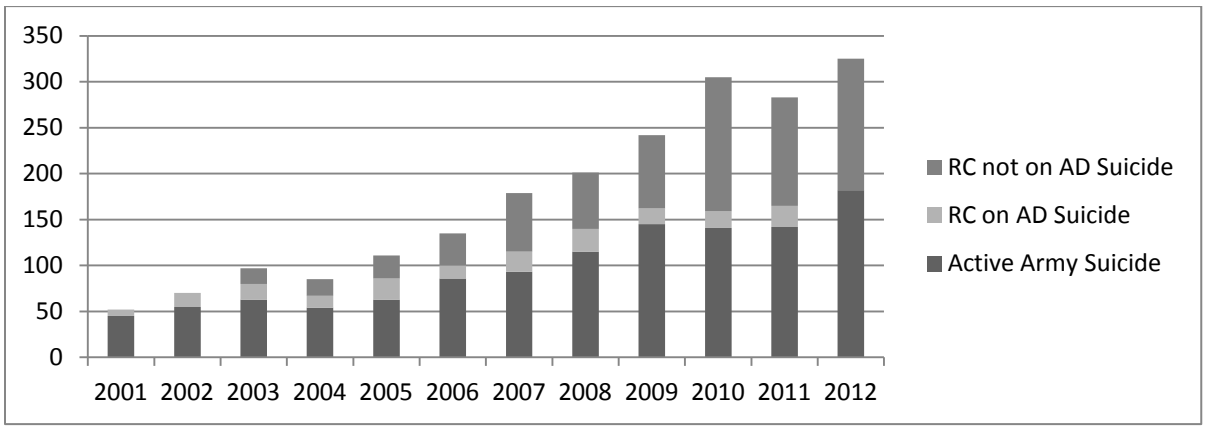


Figure 1. Yearly Number of Army Soldier Suicides, 2001 - 2012[4]

The purpose of this paper is to provide recommendations to strengthen the Army's suicide prevention strategy. Towards this end, this paper will first examine the Army's current suicide prevention strategy, with special attention to recent studies conducted by the Army, Army training programs, the Comprehensive Soldier & Family Fitness (CSF2) program, the concept of generic spirituality, and the prescribed chaplain role. Next, this paper will consider the power of religion and spirituality in the prevention of suicide, reviewing applicable psychological and psychiatric research, and surveying attitudes and the efficacy of religion as held by the American public and Soldiers. Finally, it will focus on an element not addressed in the Army's current suicide strategy – religion as a protective factor for preventing suicides – and offer recommendations to strengthen the program.

## The Army's Positive Engagement

### Recent Army Studies

To strengthen suicide prevention, in 2006 the Army Deputy Chief of Staff, G-1, formed a working group to "better integrate and synchronize efforts from various agencies, identify trends, and provide recommendations to senior Army leaders."[5] Consequently, the Army increased the number of Suicide Prevention Coordinators in the Active Component, the Army National Guard, and the U.S. Army Reserves. The Army also increased access to behavioral health for units in theater for over six months and required the creation of a multidisciplinary "Health Promotion Council to aid the commander in suicide prevention at every installation."[6] Despite these efforts, the number of suicides across both the active and reserve forces of the Army rose from 135 Soldiers in fiscal year 2006 to 305 Soldiers in fiscal year 2010.[7] At that point, the Army Vice Chief of Staff, General Peter W. Chiarelli, assembled a team which dedicated over

a year of work to “research, plan and implement health promotion, risk reduction and suicide prevention” and published The Army Health Promotion, Risk Reduction and Suicide Prevention Report 2010 (HP/RR/SP).[8]

In July 2010, General Chiarelli conducted a televised briefing and press conference to launch the initiatives, as outlined in his report for the Army’s HP/RR/SP. The overarching result was a balanced and holistic approach to suicide prevention. The approach included building comprehensive Soldier fitness, increasing access to behavioral healthcare, returning to the lost art of leadership in Garrison, and reviewing the Army Suicide Prevention Campaign for HP/RR/SP. Also taken up were corrective actions for policy, processes, and programs, which had been overlooked or not actively enforced over the preceding eight years of war. The report further identified unique multiple stressors on the Soldier and Family that had occurred over those years at war.

In January 2012, the Army released the sequel to the HP/RR/SP – the *Army 2020 Generating Health & Discipline in the Force Ahead of the Strategic Reset Report 2012*. Following six years of the Army’s vigorous efforts to reduce suicides among its Soldiers, the conclusion of OPERATION IRAQI FREEDOM, and the anticipated drawdown of U.S. military forces in Afghanistan by the end of 2014, this strategic reset report attempted to address the problems of the continuing high rate of suicide by establishing a roadmap. This roadmap sought to strengthen suicide prevention programs through a renewed focus on the complex issues of the health the force, discipline of the force, and Soldier health and misconduct that increased their risk.[9]

Army Training Programs

The All Army Activity message 079/12, released on March 27, 2012, identified annual guidance for suicide prevention training. The programs include Ask, Care, Escort

(ACE); Ask, Care, Escort – Suicide Intervention (ACE–SI); Applied Suicide Intervention Skills Training (ASIST); ASIST Training for Trainers (ASIST T4T); “Shoulder to Shoulder” awareness videos; “The Home Front” awareness videos; and the Army’s Suicide Awareness Guide for Leaders.

It is important to understand these training programs as critical elements within the Army’s suicide prevention engagement.

ACE is the base program for all Soldiers, Department of Army Civilians, and Family Members. The ACE program is a suicide prevention, awareness, and intervention training focused around the three keywords: Ask, Care, and Escort. Soldiers are taught to ask if a person is feeling suicidal, to demonstrate care for that person, and to escort the at-risk person to the appropriate professional for intervention and help. The ACE-SI training targets junior leaders and first-line supervisors, to build confidence and enable those leaders to take appropriate actions to prevent suicide with their Soldiers. ACE and ACE-SI are annual Army suicide prevention training requirements.[10] Two interactive videos augment the ACE training programs, “Shoulder to Shoulder” and “The Home Front.”[11]

ASIST is a two-day course designed to train participants in suicide prevention first aid and prepare participants to de-escalate the situation, develop an appropriate intervention plan, and ensure that appropriate follow-up treatment or care occurs.[12] ASIST training requires interactive participation in lectures, discussions, simulations, and role-plays.[13] ASIST T4T is a five-day certification course for ASIST instructors.

The Army’s target audience for ASIST training is primary gatekeepers and secondary gatekeepers. Primary gatekeepers are identified as Chaplain and Chaplains

Assistants, Army Substance Abuse Program Counselors, Family Advocacy Program Workers, Emergency Room Medical Technicians, and Medical/Dental Health Professionals.[14] Secondary gatekeepers are defined as Military Police, Trial Defense Lawyers and Legal Assistance, Inspectors General, Department of Defense School Counselors, Red Cross Workers, and First-Line Supervisors.[15]

Comprehensive Soldier & Family Fitness

The Army studies showed that after nine years of war, its Soldiers were experiencing cumulative levels of stress from their multiple deployments and home station operational tempo, and that these high levels of stress were not only affecting the Soldiers' home life but also the Soldiers' ability to perform their duty. Additionally, the Army realized their Soldiers would continue to operate under high levels of stress for the foreseeable future.[16] As a result, in 2009, the Army established the Comprehensive Soldier Fitness program, which is the primary preventative program designed to build psychological resiliency for Soldiers, Department of Army Civilians, and Family Members.[17] The Army refers to resiliency as "a set of processes that enables good outcomes in spite of serious threats."[18] In other words, resiliency gives one the ability to bounce back in spite of the adversity he or she faces.

The Comprehensive Soldier and Family Fitness (CSF2) program is comprised of four parts: the Global Assessment Tool (GAT), tailored web-based training focused on areas identified in the GAT, unit level resiliency training, and resiliency training in all leader development schools.[19] The GAT is an online self-assessment that examines four areas: emotional fitness, family fitness, social fitness, and spiritual fitness.[20] After completing the GAT, the Soldier has the opportunity to complete online self-help modules based on areas the GAT identified as needing improvement. The self-help

modules are a key component of the CSF2 program and are reinforced by unit-based Master Resiliency Trainers (MRT).

MRT is a train-the-trainer program based on established research conducted at the University of Pennsylvania.[21] Sergeants are the target population to attend the MRTs training, a ten-day program of study.[22] Upon certification, the MRTs teach resiliency skills based on an Army-wide core curriculum to fellow members of their units.

CSF2's commitment to build resiliency is an integral part of the Army's suicide prevention awareness, training, education, and mitigation strategy. Since the inception of CSF2, the Army has conducted three studies evaluating the effectiveness of CSF2's ability to build resiliency and improve psychological health of it Soldiers. The most recent technical report, issued in December 2011, focused on determining the effectiveness of MRT as part of the CSF2 program, to improve Soldier reported resiliency and psychological health (R/PH).[23]

The results of the report are encouraging. Soldiers who received MRT resiliency training had higher scores for emotional and social aspects, as measured by the GAT and compared to a control group. The improvement appears to have an enduring aspect and may serve as a buffer against future decreases in R/PH.[24]

In the domains of family and spirituality resiliency, the MRT training did not appear to be beneficial. For the family dimension, the scores actually decreased from pre- to post- training as measured by the self-assessment score reported in the GAT. There were no significant differences for spirituality, as measured by the GAT, between the control group which did not receive MRT training and the group which did.[25] The report recommends that Army leadership may want to strengthen "the family and

spiritual fitness components of the program in order to ensure that CSF2 does, indeed, address each of the four areas of R/PH."[26]

The Army's Generic Spirituality

The spiritual fitness component of CSF2 may be best described as generic spirituality. This perspective is reinforced to soldiers annually as a take the GAT.[27] Prior to starting the GAT, the Soldier views an informational screen advising that the questions regarding the spiritual dimension are not "religious" in nature:

> The spiritual dimension questions on the GAT pertain to the domain of the human spirit: they are not "religious" in nature. The Comprehensive Soldier Fitness program defined spiritual fitness as strengthening a set of beliefs, principles, or values that sustain a person beyond family, institutional, and societal sources of support. Also, spiritual fitness provides a person's sense of purpose, meaning, and the strength to preserve and prevail when faced with significant challenges and responsibilities. It promotes general well-being, enhances self-confidence, increases personal effectiveness.[28]

After completing the GAT, Soldiers have the opportunity to complete training modules focused on building resiliency in areas they may need to strengthen. In the GAT spiritual dimension training module, the connection between spirituality and religion entirely omitted. The spiritual dimension is delimited as follows: "The word spiritual or spirituality can mean many things to many people . . . but in our case here today, it's all about the human spirit." Again, "The human spirit is the essential core of a person, the deepest part of who we are."[29]

The GAT spiritual dimension training module recommends reading books about "beliefs, values, philosophies, and worldviews," listening to music, praying in ways not necessarily "tied to religion," receiving support from family and friends, making positive meanings out of life's challenges, practicing "ritual meditation," and "hunting the good stuff" found with gratitude in the everyday events of life.[30]

The section entitled “Myth Buster discusses the role of the chaplain.”[31] This section explains that Soldiers are not weak for seeking help, that chaplains will not try to convert Soldiers to their religion, that Soldiers need not identify with the religion of the chaplain, and that chaplains are advocates for general spiritual fitness.[32]

The Army’s GAT concept of spirituality promotes an inward Soldier focus without reference to transcendence and the spiritual benefits of religion. Spirituality is characterized by the Army as the Soldiers chosen inner frame of meaning apart from religion and its empowerment.

Prescribed Chaplain Role

The prescribed role for chaplains within the Army’s suicide prevention strategy has been significant, but limited in scope. Assigned to all battalion-sized units and up, Army chaplains are in a strategic position to assist Soldiers in times of need.[33] Army Regulation (AR) 600-63, *Army Health Promotion*, identifies chaplains and chaplain assistants as primary gatekeepers, defining gatekeepers as individuals “who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers and civilians in need.”[34] Within HP/RR/SP programs, the chaplain is described as an integral part of the Army’s multidisciplinary team, providing generic spiritual support or facilitating suicide prevention training.

The role of the chaplain has expanded during the past eleven years of war. On garrisons, chaplains and chaplain assistants have not only stepped up in providing increased suicide prevention counseling, but also in giving ASIST and related moral leadership training. In operations, chaplains and chaplain assistants now serve organically with military behavioral health specialists as part of the forward deployed Combat Operational Stress Control Teams. Together, the behavioral health specialist

and chaplain provide acute care for Soldiers experiencing combat stress in operational theaters of war.[35]

This role for chaplains and chaplain assistants has been significant in effects, but fallen short in potential. Consider the history and intended breadth of chaplain support.

There is a long and rich history of the Chaplaincy providing religious, moral, and spiritual support to Soldiers. The role of the chaplain in the United States military dates back to July 29, 1775, when the Continental Congress approved General George Washington's request for chaplains in the Continental Army.[36] General Washington directed his chaplains to provide religious support and care for the wounded, honor the fallen, and provide inspirational messages to Soldiers.[37] The tradition of chaplains serving the religious and spiritual welfare of Soldiers, goes even further back, to 1637, when chaplains served in New England expeditions of the Pequot War.[38]

Today, chaplains serve as an instrumentality of the United States Government to ensure that the free-exercise rights of religion are not abridged.[39] The First Amendment of the U.S. Constitution provides the foundation for chaplain service: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."[40]

Just as there is a tension between the free exercise and the establishment clauses, so is there a tension between chaplains serving as religious leaders for Soldiers and precluding any establishment of religion. AR 165-1*, Army Chaplain Corps Activities*, clarifies how this tension works out in practice:

> The Establishment Clause forbids any governmental authority from mandating a religion or way of prayer. In the pluralistic religious setting of the military, Unit Ministry Teams (UMTs) provide opportunities for religious support (worship services, religious classes, prayers, and so forth) for

> individuals from all religious backgrounds. Chaplains cooperate with each other without compromising their faith tradition or ecclesiastical endorsement requirements, to ensure the most comprehensive religious support opportunities possible within the unique military environment.[41]

Chaplain (Major General) Rutherford, Chief of Chaplains, states that Army chaplains "clearly understand the historical tension inherent in service to both church and state" and work "diligently to honor . . . the letter and spirit of the First Amendment." [42] It is the duty of chaplains to provide religious support, pastoral care, and moral and spiritual sustainment for Soldiers.[43]

This religious support is a command responsibility. The commander is charged with ensuring Title 10 religious support requirements, and establishing and maintaining a climate of high moral and ethical standards.[44] This includes providing opportunity, time, and facilities for the free exercise of religion in accordance with laws, regulations, and mission requirements.[45] Chaplains collaborate with their commanders to achieve these ends by performing their prescribed religious support duties.[46]

The fact that chaplains have made significant contributions within the Army's current suicide prevention strategy, but that the historic religious elements of their care have not been harnessed within the strategy, raises questions. Has religion demonstrated efficacy in reducing suicide risk? Does current culture even except the possibility of such efficacy? How about soldiers: have they sought out chaplains for religious support over behavioral health concerns and with demonstrated positive results?

The Power of Religion/Spirituality in the Prevention of Suicide

Psychological and Psychiatric Studies

Sigmund Freud, a critic of religion, believed religion might help people with behavioral health issues. In his writings, Freud affirmed, “If only religion can answer the question of the purpose of life one can hardly be wrong in concluding that the idea of life having a purpose stands and falls with the religious system.”[47] He further stated in a professional setting, “Religious faith may help to stifle neuroses.”[48] As the one who gave impetus to modern psychology and psychiatry, Freud’s words are significant; as a nonreligious person, he understood the importance of religion to one’s overall well-being.

Harold G. Koenig, MD, has spent decades studying this relationship between religion and health. During his 23-year career at Duke University Medical Center, he has specialized in Psychiatry and Geropsychiatry, and founded the Duke University’s Center for the Study of Religion, Spirituality, and Health.[49] In the course of his work, Koening has reviewed hundreds of research projects focused on the religion-mental health relationship. He has further identified specific behavioral categories – including psychological well-being, hope and optimism, purpose and meaning, depression, anxiety, social support, alcohol use/abuse, and delinquency and crime – that demonstrate a positive correlation between religion and desired behavior. Such studies have generally included controls that have demonstrated an overwhelmingly positive correlation for those who have held religious beliefs as compared to those not holding religious beliefs.[50] Sources consisted of primary research exceeding 630 articles and books, some of which we now review.[51]

Koenig reviewed 100 research studies focusing on psychological well-being. Seventy-nine of the studies indicated a significant positive correlation for those with religious beliefs and greater life satisfaction, happiness, positive effect, and morale. Thirteen of the studies reported no correlation between religious beliefs and psychological well-being or found complex and mixed relationships.[52] One study found a significant negative relationship between religious beliefs and psychological well-being; however, this study had design issues that may have contributed to the negative correlation. [53]

In these studies hope and optimism, as well as purpose and meaning, reported a positive relationship between religious beliefs and practices and these life quality issues, as compared to the more non-religious in the studies' population. Of 15 studies that focused on hope and optimism, 12 found a significant positive relationship. None of the studies found that the religious populations of the studies were less optimistic than those reporting nonreligious beliefs.[54] The studies also found that a positive correlation outnumbered those findings of either a neutral or a negative relationship. Fifteen of the 16 studies on purpose and meaning found a significant positive association and one found no association

Regarding 20 studies that investigated the relationship between religion and social support, 19 found "a statistical significant positive association between indicators of religious involvement and social support."[55]

A study on depressed inpatients conducted by Dervic et al., investigated the relationship between religion and suicide attempts.[56] The participants in the study were diagnosed as having a current major depressive episode; the diagnoses were confirmed

by a consensus conference of healthcare providers led by a physician or PhD level clinicians. Structured medical and behavioral health histories were taken from the participants, including the number, if any, of past suicide attempts.[57] The participants self-identified as either having a specific religious affiliation or having no religious affiliation. Using diagnostic instruments and observations, there was no differences in levels of depression between the two groupings of religious affiliation and no religious affiliation.

Dervic et al., found participants with no religious affiliation reported a higher number of suicide attempts, experienced more incidents of suicide ideation, and had a higher number of first-degree relatives who had committed suicide than participants who identified themselves as religiously affiliated.[58] The authors went on to state "Of note, suicidal ideation, a risk factor for suicidal acts, has been found to be inversely related to religion. Therefore, religion may provide a positive force that counteracts suicidal ideation in the face of depression, hopelessness, and stressful vents."[59] The study, completed in 2004, concluded that, although psychiatrists generally do not include a patient's religious affiliation into their treatment, the patient's religious affiliation may provide a resource assisting in the prevention of suicidal acts. Only two years after Dervic et al., completed their study, the March 2006 *Psychiatric Annals*, a journal of continuing psychiatric education, dedicated an entire issue to religious and spiritual assessment of patients.

In 2008, Gearing and Lizardi conducted two literature reviews of peer-reviewed journal articles, written prior to 2008, to establish general practice guidelines for clinical assessment of depressed and suicidal patients in order to evaluate the influence and

impact of religiosity on their patient's suicide risk.[60] They offered four guidelines for the clinician to assess:

1. The importance of religion to the client and their identity;
2. The role of religiosity during previous times of stress and difficulties;
3. How suicide is conceptualized and perceived in the client's religion;
4. The value of strengthening the client's religiosity and participation in their religion.[61]

Clinicians have only recently begun to routinely assess the religiosity of their patients. From the research reviewed, clinicians appear to be more accepting of research showing that "religious involvement is related to better coping with stress and less depression, suicide, anxiety and substance abuse."[62]

Military Spirituality Study

In 2009, the National Defense University conducted the Army's Excellence in Character, Ethics, and Leadership study (EXCEL). Surveying over 2,570 Soldiers deployed to Iraq, EXCEL sought to measure spirituality as one of the individual variables of Soldier resiliency.[63] In the study, Soldiers typically described their spirituality in terms of "recognizable religious identifiers such as prayer, chapel attendance, and corporate worship, which are common to organized religion."[64] At a minimum, EXCEL demonstrated that Soldiers experience spirituality through religious-based activities, and that religious-based spirituality translates into increased resiliency with the additional benefit of a strengthened personal ethic. [65]

Acceptance of Religion by the American Public

While there will always be a vocal minority discouraging the constitutional right of the free exercise of religion, the American public accepts turning to religion as a way of handling stress in times of a crisis. While not widely reported, the Massachusetts Medical Society conducted a national survey of stress reactions following the attacks of

September 11, 2001. The survey discovered that 44 percent of adults reported one or more substantial symptoms of stress, and that 90 percent had one or more symptoms to at least some degree.[66] Ninety-eight percent of the respondents coped with their stress by using their social support system and by talking with others about their thoughts and feelings concerning the events of September 11.[67] The second highest response, to address their stress reaction, was to turn to religion; 90 percent answered they had turned to prayer or religion.[68] Forty-four percent of the respondents stated they turned to religion "A Lot," 31 percent responded "A Medium Amount," 15 percent "A Little Bit" and 10 percent responded "Not At All."[69] The Massachusetts Medical Society survey closely parallels a Pew study that found that 93 percent American public have a belief in God.[70]

A belief in God continues to be an enduring aspect of American culture even as the number of adults reporting that they are unaffiliated with a specific religion rose to nearly 20 percent of the adult population in 2012. The Pew Research Center released a study in October 2012 titled "'Nones' on the Rise: One-in-Five Adults Have No Religious Affiliation."[71] The Pew study reported that out of the estimated 234 million adults in the United States, 13 million are self-described atheists or agnostics and 33 million state they have no particular religious affiliation. Interestingly, being unaffiliated does not necessarily indicate a lack of religious belief or spirituality. Pew Research Centers Forum conducted an additional survey in conjunction with the Public Broadcasting System television program "Religion & Ethics NewsWeekly," and this study found that approximately 31 million of the 46 million unaffiliated Americans believe in God.[72] This results in an estimated 217 million American adults with a belief in God. Of the estimated 217 million Americans believing in God, 73 percent are Christians, six percent

are other faiths, 19.6 percent are unaffiliated, and two percent responded, “don’t know.”[73] The Pew study categorized Christians as Protestant (with various subsets), Catholic, Mormon, and Orthodox (with various subsets). The other faith categories included Judaism, Muslim, Buddhist, Hindu, or other responses to the question “something else.”[74]

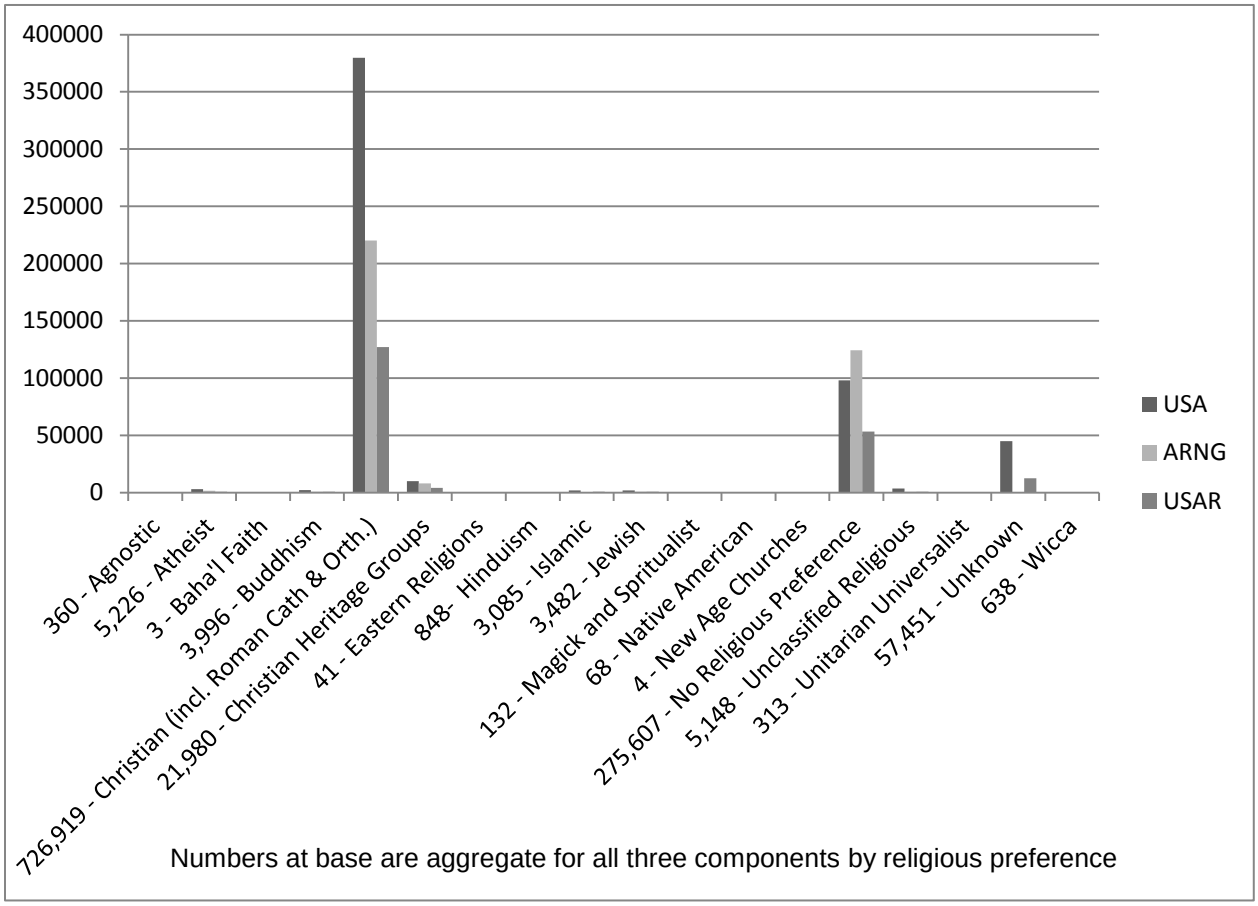


Figure 2: Self-Identified Religious Preference of U.S. Army by Component[75]

## What’s Missing in the Army’s Suicide Prevention Strategy?

### Soldiers: Religion and the Numbers

Soldiers understand the significance of religious support for behavioral health issues. In a recent study based on data from 2005 Department of Defense Survey of Health Related Behavior Among Active Duty Military Personnel, 55 percent of deployed

soldiers who sought assistance for behavioral health-related issues met with a chaplain.[76]

Religiosity in the US Army, as measured by self-identified religious preference of Soldiers, exceeds 69 percent. This number grows to 94 percent if the number of soldiers who reported no specific religious preference is added to the aggregate numbers. Only 5,586 out of 1,105,301 Soldiers self-identified as agnostic or atheist meaning 0.005 percent of the Total Army Force identified themselves as either having no belief in God or one who believes that it is impossible to know whether God exists: see Figure 2.[77]

Omission of Religion

Older Army publications and guides have recognized the relationship of religion to behavioral health. The 1987 Department of Army Pamphlet (DA PAM) 600–63–12, *The Army Health Promotion Program*, states that spiritual fitness is derived from "religious, philosophical, or human values and form[s] the basis for character, disposition, decisionmaking, and integrity."[78] Unit activities in the DA PAM include "chaplain-led study and meditation groups," and community activities include "religious services and education."[79]

The December 2007 draft Department of Army suicide prevention program quick reference guide, religion and active religious affiliation or faith are identified as contributing to preventing suicides:

What Helps?
- Intact social supports, including marriage
- *Active religious affiliation or faith*
- Presence of dependent young children
- Ongoing supportive relationship with a caregiver
- Adhering to treatment for depression or substance abuse
- Living close to medical and mental health resources

- Awareness that suicide is a result of illness, not weakness
- Reinforcement of problem-solving and coping skills

Why Is It Important to Stick Around?

- Family
- Hope for the future
- Enjoyable activities or objects
- Friends
- Obligations to others or protecting others
- *Religion*[80]

Since these documents, Army suicide prevention programs have moved towards replacing explicitly religious references with generic spirituality. The current *Army Suicide Awareness Guide for Leaders* references chaplains several times as a resource for commanders, but does not address religion or active religious affiliation as elements of the Army's suicide prevention program.[81]

Neither the *Army Health Promotion, Risk Reduction & Suicide Prevention: Report 2010* nor the *Army 2020 Generating Health & Discipline in the Force Ahead of the Strategic Reset Report 2012* mention religion or an active religious affiliation as contributing to suicide prevention. The role of the chaplain is only addressed twice in the Army 2020 report, each being only a notation of increased numbers of chaplains. The first occurrence notes that the Army is making significant strides in hiring additional chaplains. The second touts the expansion in the number of "front-line service providers across the Force, to include chaplains and chaplain assistants."[82]

The Army has omitted active religious affiliation or religious faith as elements in their suicide prevention programs. The religious elements have transitioned to concepts of generic spirituality. The Army's generic spirituality can be summarized as a personal quest of the human spirit to discover the core of one's self.

Historical and Linguistic Roots

Historically, the concepts of spirituality and religion were closely related. In western culture, one can trace the connection back to ancient Greece. For the Greeks, spirit and spirituality involved four interrelated components: the blowing of the wind, the breathing of that wind or air, the human animation or spirit that existed by way of that breathing, and the spirit of God that thereby created and sustained the spirit of man. Human spirituality, as understood by the ancient Greeks, assumed the element of God's spirit.[83]

In modern American English, spirituality is defined as "something that in ecclesiastical law belongs of the church or to a cleric as such, sensitivity or attachment to religious values, or the quality or state of being spiritual."[84] Spirituality as defined by the American Psychological Association is "1. a concern for or sensitivity to the things of the spirit or soul, especially as opposed to material things. 2. more specifically, a concern for God and religion in a sensitivity to religious experiences. 3. the fact or state of being incorporeal."[85]

The English word religion traces its origin to the Latin word *religo*. The etymology of *religo* is disputed; however, the most commonly accepted origin of the word is *religare*, "the sense of persons being bound to God or to superior powers."[86] Merriam–Webster's Collegiate Dictionary defines the term religion as "the service and worship of God or the supernatural, commitment or devotion to religious faith" or "observance, and a personal set of institutionalized system of religious attitudes, beliefs, and practices."[87]

These definitions and linguistic roots show the close connection of spirit and spirituality to religion. These connections cross ancient, nonprofessional, professional,

and behavioral health provider definitions. It is only in recent history that spirituality and religion have been separated.

## Conclusion and Recommendations

In spite of the numerous programs that the U.S. Army has introduced to reduce suicides, the annual number of suicides among Soldiers continues to trend up, reaching an all-time high in 2012. The Army CSF2 and MRT programs and have proven to be effective in two of the four domains. The family and spiritual dimensions modules of MRT are not working. Generic spirituality in the Army CSF2 program is not achieving its intended effect. The Army should revise spiritual dimension module training to include, and emphasize, the benefits of the religious component of the spiritual dimension.

The Army's apparent apprehension of referring to religion or God in their suicide prevention programs, as demonstrated by removing such references, should be alleviated when one considers 90 percent of the American public turns to God and religion in times of crisis, and approximately 93 percent of the adults in America believe in God. Research and studies show religion is a protective factor in the prevention of suicides.[88]

The Army's approach to spirituality is not succeeding and should be expanded to include an emphasis on Soldier's religious involvement while not endorsing any specific religion. An Army-led CSF2 evaluation report showed no improvement in pre-and post-spirituality scores as measured by the GAT.[89] The Army's spirituality training, in both the MRT and GAT training modules, should be rewritten to include the positive benefits of religion. The lessons should not advocate any specific religion, or against non-religion, but should identify that one's degree of religiosity can serve as a protective factor against suicide. Army chaplains should assist in training the spirituality block of MRT

instruction. Army chaplains have demonstrated for over two hundred years the ability to strike a balance between the establishment and free exercise clauses of the First Amendment.

While Soldiers understand the significance of religious support for behavioral health issues, the institutional Army has backed away from encouraging commanders to embrace religious support as part of suicide prevention.[90] It is time for commanders to frame chaplain-led worship, religious counseling services, and pastoral support *as part of the Army's suicide prevention programs*. The following recommendations from the National Defense University's EXCEL study should be implemented:

> •Acknowledge the value and positive impact of religious and spiritual activities on ethical behavior and resilience.
> •Promote Soldiers' participation in spiritual activities as a means of moral development within the limitations of regulations. (Although this research was not structured to demonstrate a clear causal relationship, there are correlations which imply influence.)
> •Ensure soldiers have opportunity to practice their faith.
> •Provide adequate resources (funding, time on the training schedule) to unit chaplains to offer spiritual fitness training and activities.[91]

The Army should institute these recommendations. Implementation will lead to increased resiliency the force.

Future Research

There is an opportunity right now for the Army to collaborate with the Department of Veterans Affairs and a leading external medical or behavioral health teaching institution. Joining forces, the three organizations can conduct studies of service members and veterans who are behavioral health inpatients and outpatients to examine the role of religion as a protective factor against suicide. The Dervic et al. study can serve as a model for an initial investigation.[92] If the findings of Dervic et al. are replicated, it will provide the U.S. Army with solid footing to reassert the importance of

the chaplaincy and religious support activities as protective factors in preventing suicides of Soldiers.

## Endnotes

[1] Peter W. Chiarelli, *The Army Health Promotion, Risk Reduction, Suicide Prevention, Report 2010*, (Washington, DC: US Department of the Army, July 28, 2010), 2.

[2] "Army Releases December 2012 and Calendar Year 2012 Suicide Information," February 2, 2013, linked from *US Department of Defense News Release*, at "02/01/2013: Army Releases December 2012 and Calendar Year 2012 Suicide Information," http://www.defense.gov/releases/release.aspx?releaseid=15797 (accessed February 2, 2013). (As of February 1, 2013, 78 of the 325 reported suicides were still under investigation.)

[3] Peter W. Chiarelli, "*The Army Health Promotion,"* 126.

[4] Manpower & Reserve Affairs/Deputy Chief of Staff (DCS), United States Army, G–1, *M&RA/DCS G-1 Smart Book*, *as of December 1, 2012*, by LTC Tom Alexander. Background and source data for leadership situational awareness; Department of the Army. Washington, DC, December 1, 2012, 9; "Army Releases December 2012 and Calendar Year 2012 Suicide Information. Abbreviations: Active Duty (AD) and Reserve Components (RC); Reserve Component soldiers on active duty are reported in the active Army category for calendar year 2012.

[5] George W. Casey, Junior, and Pete Geren, *America's Army: The Strength of the Nation, 2008 Army Posture Statement* 2008, February 26, 2008. (Washington, DC: U.S. Department of the Army, February 26, 2008.) http://www.army.mil/aps/08/information_papers/sustain/Army_Suicide_Prevention_Program.html (accessed December 22, 2012). US Department of the Army, The Deputy Chief of Staff, G-1, is the responsible official to the Assistant Secretary Army (Manpower & Reserve Affairs), and provides advice and assistance to the Assistant Secretary regarding current and future personnel readiness and well-being of the Army through the development and integration of policies and programs for the three components of the Army and Department of Army civilian and contractor employees. For a detailed explanation of The Deputy Chief of Staff, G-1, duties and responsibilities see the Army G-1 website at http://www.armyg1.army.mil/dcsg1.asp.

[6] George W. Casey, Junior. And Pete Geren, *America's Army: The Strength of the Nation.*

[7] Manpower & Reserve Affairs/Deputy Chief of Staff (DCS), United States Army, G–1, *M&RA/DCS G-1 Smart Book*, 9.

[8] Peter W. Chiarelli, "*The Army Health Promotion,"* i.

[9] Peter W. Chiarelli, *Army 2020 Generating Health & Discipline in the Force Ahead of the Strategic Reset Report 2012*, (Washington, DC: Department of Army, January 19, 2012), 159.

[10] US Department of the Army, United States Army, G–1, "All Army Activity (ALARACT) Message 079/12, Subject: Army Suicide Prevention Program (Annual Guidance on Suicide Prevention Training)", Washington, DC, March 27, 2012.

[11] While not part of the curriculum of ACE, these videos foster discussion between the trainer and the Soldiers, build Soldiers' confidence in the ability to recognize when another is in need, and model the appropriate intervention skills taught in the ACE program. US Department of the Army, "US Army Public Health Command Suicide Prevention Products," Suicide Prevention Training PowerPoint Presentations, https://www.us.army.mil/suite/designer (accessed December 1, 2012).

[12] Suicide Prevention Resource Center, "Best Practices Registry Section III: Adherence to Standards Applied Suicide Intervention Skills Training (ASIST)," Suicide Prevention Resource Center, http://www.sprc.org/bpr/section-III/applied-suicide-intervention-skills-training-asist (accessed December 2, 2012).

[13] Ibid.

[14] U.S. Department of the Army, *Army Health Promotion, Army Regulation 600-63* (Washington, DC: US Department of the Army, May 7, 2007/RAR September 20, 2009), 17. The ASIST program is complementary to the ACE program. In the ACE program, Soldiers are taught to escort personnel at risk to either a primary or secondary gatekeeper, as appropriate.

[15] U.S. Department of the Army, *Army Health Promotion*, 17.

[16] Karen J. Reicich, Martin E. P. Seilgman, and Sharon McBride, "Master Resiliency Training in the U.S. Army," *American Psychologist*, 66, no. 1 (January 2011): 25.

[17] Paul B. Lester et al., *The Comprehensive Soldier Fitness Program Evaluation Report #3: Longitudinal Analysis of the Impact of Master Resilience* (Washington, DC: U.S. Department of the Army, December 2011), C; George W. Casey Jr., "Comprehensive Soldier Fitness A Vision for Psychological Resiliency in the U.S. Army," *American Psychologist*, 66, no. 1 (January 2011): 1-2; Comprehensive Soldier Fitness has expanded to include Family Members, and is now referred to as Comprehensive Soldier & Family Fitness (CSF2).

[18] Karen J. Reicich, Martin E. P. Seilgman, and Sharon McBride, "Master Resiliency Training in the U.S. Army," *American Psychologist*, 66, no. 1 (January 2011): 25.

[19] George W. Casey Jr., "Comprehensive Soldier Fitness A Vision for Psychological Resiliency in the U.S. Army," *American Psychologist*, 66, no. 1 (January 2011): 2-3.

[20] The GAT consists of approximately 100 questions and takes on average 10 to 15 minutes to complete.

[21] Paul B. Lester, et al., *The Comprehensive Soldier Fitness Program Evaluation Report #3*," 3.

[22] Sergeants are first-line leaders and supervisors who routinely have day-to-day contact with their soldiers. For background information on master resiliency training in the Army see Karen J. Reicich, Martin E. P. Seilgman, and Sharon McBride, "Master Resiliency Training in the U.S. Army," *American Psychologist*, 66, no. 1 (January 2011): 24-25.

[23] Paul B. Lester, et al., *The Comprehensive Soldier Fitness Program Evaluation Report #3*," 1, 3-4 and 23.

[24] The 18 to 24 year old age group showed the greatest improvement for emotional and social aspects; however, they started with a significantly lower score than older Soldiers. MRT training may be inoculating younger Soldiers more rapidly than their older counterparts who have learned coping skills over time. Paul B. Lester, et al., *The Comprehensive Soldier Fitness Program Evaluation Report #3*," 22-23.

[25] Paul B. Lester, et al., *The Comprehensive Soldier Fitness Program Evaluation Report #3*," 23-24.

[26] Paul B. Lester, et al., *The Comprehensive Soldier Fitness Program Evaluation Report #3*," 24.

[27] Yearly all soldiers are reminded of the Army's generic view of spirituality because the GAT is an annually requirement for all Soldiers. While the Soldier's Chain of Command cannot view the Soldier's results of the GAT, the Change of Command does monitor compliance with the annual requirement to ensure all Soldiers in their command are compliant with this requirement.

[28] U.S. Department of the Army, "Comprehensive Soldier Fitness Module - Spiritual Dimension Module Transcript," n.d., linked from *The Soldier Fitness Tracker home page* at https://www.sft.army.mil/Protected/Secured/Dashboard/Soldier2.aspx (accessed January 14, 2013 - Military Common Access Card (CAC) required to access).

[29] U.S. Department of the Army, "Comprehensive Soldier Fitness Module - Spiritual Dimension Module Transcript," n.d., linked from *The Soldier Fitness Tracker home page* at https://www.sft.army.mil/CSFModules/Dimensions/Default.aspx?c=4&item=17 (accessed January 14, 2013 - Military Common Access Card (CAC) required to access).

[30] U.S. Department of the Army, "Comprehensive Soldier Fitness Module - Spiritual Dimension Module Transcript," n.d., linked from the soldier fitness tracker *home page* at https://www.sft.army.mil/CSFModules/Dimensions/Default.aspx?c=4, https://www.sft.army.mil/CSFModules/Dimensions/Default.aspx?c=4&item=17, https://www.sft.army.mil/CSFModules/Dimensions/Default.aspx?c=4&item=18, https://www.sft.army.mil/CSFModules/Dimensions/Default.aspx?c=4&item=19, https://www.sft.army.mil/CSFModules/Dimensions/Default.aspx?c=4&item=20, https://www.sft.army.mil/CSFModules/Dimensions/Default.aspx?c=4&item=8 (accessed January 14, 2013 - Military Common Access Card (CAC) required to access).

[31] U.S. Department of the Army, "Comprehensive Soldier Fitness Module" https://www.sft.army.mil/CSFModules/Dimensions/Default.aspx?c=4&item=17.

[32] Ibid.

[33] Most battalions have Army chaplains organically assigned to them; however, some battalions of less than 200 soldiers are without organic chaplains and rely on area coverage for religious support.

[34] U.S. Department of the Army, *Army Health Promotion*, 17.

[35] Karen Besterman-Dahan, Susan W. Gibbons, Scott D. Barnett, and Edward J Hickling, "The Role of Military Chaplains in Mental Health Care of the Deployed Service Member," *Military Medicine* 177, no. 9 (September 2012): 1028. Chaplain assistants are enlisted soldiers and noncommissioned officers who support chaplains on a daily basis. Their training includes specialized peer counseling for combat stress casualties.

[36] Donald L. Rutherford, "The Chief of Chaplains Strategic Roadmap Connecting Faith, Service, and Mission," 2012, http://www.usachcs.army.mil/, 10 (accessed December 15, 2012).

[37] Ibid

[38] Robert K. Right, Jr., The *Continental Army*, (Washington, DC: US Army Center of Military History, 1983), 38, http://www.history.army.mil/books/RevWar/ContArmy/CA-fm.htm (accessed December 15, 2012).

[39] U.S. Department of the Army, *Army Chaplain Corps Activities*, Army Regulation 165-1 (Washington, DC: US Department of the Army, December 3, 2009), 1.

[40] U.S. Constitution, Bill of Rights, First Amendment.

[41] U.S. Department of the Army, *Army Chaplain Corps*, 1.

[42] Donald L. Rutherford, "The Chief of Chaplains Strategic Roadmap."

[43] U.S. Department of the Army, *Army Chaplain Corps*, 1-2.

[44] U.S. Department of the Army, *Army Chaplain Corps*, 1, 3; U.S. Joint Chiefs of Staff, Religious Affairs in Joint Operations, Joint Publication 1-05 (Washington, DC: U.S. Joint Chiefs of Staff, November 13, 2009), II-1. In Army Doctrine, the activities and services of the chaplain and chaplain assistant are referred to as "religious support"; the Joint Doctrine refers to their activities as "religious affairs". Commanders must provide equitable support for religious, spiritual, moral, and ethical activities for all Soldiers within their command.

[45] U.S. Department of the Army, *Army Chaplain Corps*, 3, 10-11.

[46] U.S. Department of the Army, *Army Chaplain Corps*, 10-11. Chaplain duties include religious services, pastoral care and counseling, moral and spiritual support, spiritual fitness of events, and religious education and youth ministry.

[47] Sigmund Freud, *Civilization and its Discontents* (1930) trans. James Strachey, *Standard Addition of the Psychological Works of Sigmund Freud*, (London: Hogarth Press, 1962), 25, quoted in Harold G. Koenig, "Religion and Medicine II: Religion, Mental Health, and Related Behaviors," *International Journal of Psychiatry* in Medicine 31, no. 1 (01, 2001): 98, in ProQuest (accessed September 3, 2012).

[48] Harold G. Koenig, "Religion and Medicine II: Religion, Mental Health, and Related Behaviors," *International Journal of Psychiatry in Medicine* 31, no. 1 (01, 2001): 98, in ProQuest (accessed September 3, 2012).

[49] Harold G. Koenig, B.S., R.N., M.D., M.H.Sc., is the founder and former director of Duke University's Center for the Study of Religion, Spirituality and Health, and is now Director of Duke's current Center for Spirituality, Theology and Health; he has published extensively in the fields of mental health, geriatrics, and religion, with nearly 400 scientific peer-reviewed articles and book chapters and 40 books in print or in preparation; he is the former editor-in-chief of the International Journal of Psychiatry in Medicine, and is on the editorial boards of several professional journals, Duke University Center for Spirituality, Theology and Helps, "*About Harold G. Koenig, MD*," Duke University, http://www.spiritualityandhealth.duke.edu/about/hkoenig/ (accessed March 10, 2013).

[50] Harold G. Koenig, "Religion and Medicine I: Historical Background and Reasons for Separation," *International Journal of Psychiatry in Medicine* 30, no. 4 (2000/2001): 388, in ProQuest (accessed September 3, 2012).

[51] Koenig conducted a comprehensive and systematic review of research on religion and mental health conducted during the 20th century. The research included database searches to identify quantitative studies that examined the religion-mental health relationship. Because the databases only went back to the mid-1960s, footnotes and references of all articles were reviewed and articles published prior to the mid-1960s were identified and retrieved for inclusion in the review. Additionally published books examining the topic were reviewed leading to over 630 reports being discovered. A significant majority found a positive relationship that far outnumbered the findings of either no association or negative relationship.

[52] Harold G. Koenig, "Religion and Medicine II," 99.

[53] Harold G. Koenig, "Religion and Medicine II," 99.

[54] Harold G. Koenig, "Religion and Medicine II," 99.

[55] Harold G. Koenig, "Religion and Medicine II," 101-102. Five of the studies involved the use of randomize populations. One study investigated social support systems of a churchgoing population; family members were found to be more likely than fellow church members to provide a social support system to the study population. Koenig pointed out that one might expect to find family members having a greater importance in one's life than church members.

[56] Kanita Dervic, Maria A. Oquendo, Michael F.Grunebaum, Steve Ellis, Ainslie K. Burke, and J. John Mann, "Religious Affiliation and Suicide Attempt," *The American Journal Psychiatry* 161, 12 (December 2004): 2303.

[57] The study excluded inpatients that were currently abusing any substances or diagnosed with a neurological illness or other active medical condition.

[58] Kanita Dervic et al., "Religious Affiliation and Suicide Attempt," 2305.

[59] Ibid., 2306.

[60] Dana Lizardi and Robin E. Gearing, "Religion and Suicide: Buddhism, Native American and African Religions, Atheism, and Agnosticism," *Journal of Religious Health* 49 (2010): 377,378, 382, in ProQuest (accessed December 7, 2012).

[61] Dana Lizardi and Robin E. Gearing, “Religion and Suicide,” 382.

[62] Harold G. Koenig, “Research on Religion, Spirituality, and Mental Health: A Review,” *Canadian Journal of Psychiatry*, vol. 54, no. 5 (May 2009): 289, in ProQuest (accessed September 3, 2012); Mary Linda O'Reilly, “Spirituality and Mental Health Clients,” *Journal of Psycho Social Nursing* 42, no. 7 (July, 2004): 44-52, in ProQuest (accessed December 14, 2012).*The Psychiatric Annals* and the Gearing and Lizardi articles are targeted for doctoral level practitioners’ implementation. The importance of religion and spirituality is also being incorporated at the nurse and nurse practitioner levels.

[63] Franklin Eric Wester, “*Soldier Spirituality in a Combat Zone: Preliminary Findings About Correlations with Ethics and Resiliency*,” in Fort Leavenworth Ethics Symposium : Exploring The Professional Military Ethic : Symposium Report, eds. Mark H. Wiggins and Larry Dabeck (Leavenworth, KS: CGSC Foundation Press, 2011), 285-286. Of the original 2,572 surveys issued, 1,366 were returned and 1,236 contain valid responses.

[64] Franklin Eric Wester, “Soldier Spirituality in a Combat,” 290.

[65] Franklin Eric Wester, “Soldier Spirituality in a Combat,” 291.

[66] Mark A. Schuster et al., “A National Survey of Stress Reaction After the September 11, 2001, Terrorist Attacks,” *New England Journal of Medicine* 345, no. 20 (November 15, 2001) 1508-1509, in ProQuest (accessed December 7, 2012).

[67] Ibid., 1510-1511.

[68] Ibid.

[69] Ibid., 1510.

[70] Cary Funk and Greg Smith, “’Nones’ on the Rise: One-in-Five Adults Have No Religious Affiliation,” October 9, 2012, Pew Research Center, The Pew Forum on Religion & Public Life, http://www.pewforum.org/Unaffiliated/nones-on-the-rise.aspx (accessed October 27, 2012), 13. Based on the Pew study there are an estimated 234 million American adults and 217 million believe in God, this equates to 92.7 percent of Americans believing in God. The Massachusetts Medical Society 90 percent response of Americans turning to God buttresses pew's approximation of 92.7 percent believing in God.

[71] Ibid. The Pew study notes the term “nones” has been in use by scholars of religion since the 1960s, the Pew Research Centers Form on Religion & Public Life will continue to use “religiously unaffiliated” as the preferred term for Americans who answer surveys stating they are atheist, agnostic or have no particular religion. This is a deliberate choice made to avoid a negative connotation to those who respond they are unaffiliated with a formal religious group.

[72] Ibid., 9-10.

[73] Ibid., 13.

[74] Ibid.

[75] Ibid.

[76] Karen Besterman-Dahan et al., "The Role of Military Chaplains in Mental Health Care of the Deployed Service Member," *Military Medicine* 177, no. 9 (September 2012): 1030. Thirty percent of the Soldiers sought only a chaplain for assistance and 25 percent sought both a chaplain in their behavioral health professional.

[77] Total number of Active Component (AC), Army National Guard (ARNG), and United States Army Reserve (USAR) Soldiers on active duty as of 30 September 2012 was 1,105,301: 546,057 AC, 358,078 ARNG, and 201,166 USAR. Religious affiliation is based on self-reported data by the Soldier through human resource channels, and compiled by the Defense Manpower Data Center. 766,657 reported a specific religious affiliation, 275,607 reported no specific preference, and 5,586 reported being either agnostic or atheist. Department of Defense, Defense Manpower Data Center, Religious Preference Data Report as of 30 SEP 12 - DRS#59608; U.S. Department of the Army, *Religious Requirements and Practices of Certain Selected Groups: A Handbook Supplement for Chaplains*, DA PAM 165-13-1 (Washington, DC: US Department of the Army, April 1980).

[78] U.S. Department of the Army, *The Army Health Promotion Program*, DA PAM 600–63–12 (Washington, DC: US Department of the Army, September 1, 1987), 1.

[79] Ibid., 7-8.

[80] U.S. Department of the Army, "Deputy Chief of Staff, G-1 Army Suicide Prevention Program, – Quick Reference Guide – Draft," December 2007, http://www.armyg1.army.mil/hr/suicide/docs/Commanderspercent20Toolpercent20Kit/Quickpercent20Referencepercent20Pamphletpercent20(ASPP).pdf (accessed October 19, 2012); emphasis added. As of March 12, 2013, the guide was still posted on the Department of the Army's Deputy Chief of Staff, G-1 suicide prevention website.

[81] U.S. Department of the Army, *Army Suicide Awareness Guide for Leaders*, (Washington, DC: QuickSeries Publishing, 2012), QuickSeries mobile application for android available for download from http://www.quickseries.com/index.php?viewprod=43508 (accessed December 7, 2012).

[82] Peter W. Chiarelli, *Army 2020 Generating Health*, 70.

[83] Gerhard Friedrich, ed., *Theological Dictionary of the New Testament*, trans. and ed., Geoffrey W. Bromiley, (Grand Rapids, MI: WM. B. Eerdmans Publishing Company, 1968), 352 - 359; P. Sheldrake, *A Brief History of Spirituality*, (Boston; Blackwell Publishing, 2007) quoted in Harold G. Koenig, "Research on Religion, Spirituality, and Mental Health: A review." *Canadian Journal of Psychiatry* 54, no. 5 (May, 2009): 284, in ProQuest (accessed September 3, 2012); Gerhard Friedrich, ed., *Theological Dictionary of the New Testament*, trans. and ed., Geoffrey W. Bromiley, (Grand Rapids, MI: WM. B. Eerdmans Publishing Company, 1968), 396-439. The English word spirituality traces its origins to the Latin word *spiritualis*, from *spiritus* "of breathing, of the spirit" and the Latin word spiritualis is derived from the Greek word *pnematikos*. One concrete example of this is in Paul's first century letters to the people of Roman and Corinth. Paul's letters to the Romans and Corinthians were written in Greek. In writing in Greek, Paul would be referring to spirit in two different ways. The first would be spirit as part of the tripartite understanding of the human existence: body - the corporal, mind - the soul, and spirit -

understood as the trust in God bringing life to the body. The second Way, Paul would use spirit is in a comparison to spirit versus the flesh. The flesh referring to the fallen existence. Spirit meaning the new birth by God through the Spirit; through the Spirit by the breath of life for humanity.

[84] Merriam-Webster's, Incorporated*, Merriam-Webster's Collegiate Dictionary*, 11th ed, (Versailles, KY: Quad Graphics, 2012), 1024.

[85] Gary R. VandenBos, ed., *American Psychological Association Dictionary of Psychology*, (Washington, DC: American Psychological Association, 2007), 884; Incorporeal refers to lacking a physical body or existing as a spirit.

[86] S.A. Nigosian, *World Religions A Historical Approach*, 3rd ed. (Boston: Bedford/St. Martin's, 2000), 5.

[87] Merriam-Webster's, Incorporated*, Merriam-Webster's,* 1051-1052.

[88] Robin E. Gearing and Dana Lizardi, "Religion and Suicide," *Journal of Religion and Health* 48, no. 3 (September 2009): 332-341, in ProQuest (accessed December 7, 2012).

[89]Paul B. Lester, et al., "The Comprehensive Soldier Fitness Program Evaluation Report #3," 1, 3-4 and 23.

[90] Karen Besterman-Dahan et al., "The Role of Military Chaplains," 1030. Fifty-five percent of deployed soldiers, seeking assistance for behavioral health related issues, met with a chaplain.

[91] Franklin Eric Wester, "Soldier Spirituality in a Combat," 300.

[92] Kanita Dervic et al., "Religious Affiliation and Suicide Attempt," 2303 - 2308.